The Role of Federal Education and Labor in School Based Health Clinics

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INTRODUCTION

Thank you for holding hearings and for the opportunity to submit testimony on this very important topic. My other title for this subject is "The Clinic in the Classroom." This matter has grave implications for the health, freedom, and privacy of America's precious school children and their families. These issues have raised serious concerns for me as a mother, a physician, and a taxpayer.

Provisions of, loopholes in, or goals of the Healthy People 2000 program, the Goals 2000 Educate America Act, the School to Work (STW) Opportunities Act, the Early Periodic Screening, Detection and Treatment (EPSDT) program under Medicaid as outlined in the Omnibus Budget Reconciliation of 1989 (OBRA), Title I of the current Elementary and Secondary Education Act (ESEA)/Improving America's Schools ACT (IASA), and a joint program of the Departments of Education and Health and Human Services called Caring Communities have resulted in a massive restructuring and merging of health, education and labor programs.

The schools are "one stop shopping centers" for all of these services. School-based or school-linked clinics (SBCs) are the vehicles and tax dollars, especially through Medicaid, are the funding mechanism. The emphasis in our public schools is no longer on the academic liberal arts education required of responsible citizens in a free republic, but instead on medicalized and psychologized mixture of attitudes beliefs, feelings, behaviors, and job skills. Our children are seen no longer as individual human beings with unlimited potential, but as human resources or human capital in a planned and managed economy.

Throughout this testimony, the major programs, examples of problems and abuses and the consequences will be outlined. Although there are many disturbing consequences, the three worst are:

- ✂The massive gathering of personal medical and family data from students resulting in profiles and diagnoses of children for disorders that often have more to do with compliance with the mandates of these programs and increased disability funding for the schools than with the medical reality for the child

- ✂The loss of parental control in the education and medical care of their own children to the "It takes a village of government bureaucracies to raise a child" mentality

- ✂The back door implementation of the Clinton health care plan that was overwhelmingly rejected by the American people through their elected representatives.

HEALTHY PEOPLE 2000

This 1990 policy document from the Department of Health and Human Services lays the groundwork for health care reform as it was attempted in 1993 and then later merged with the education goals of Goals 2000 to develop the extensive delivery of health care and social services through the schools that has developed currently.

The report consists of 300 "measurable" health care goals divided into 22 areas, such as Mental Health and Mental Disorders, Family Planning, and Educational and Community-Based Programs. These three are the most relevant to what is happening in education and school-based clinics today.

Under Mental Health and Mental Disorders category, one objective that raises concern for school children is the following: "(Developmental) Increase the proportion of children with mental health problems that receive treatment."[1] As will be seen below in the discussion of EPSDT and Medicaid, tax dollars are being used to treat children with powerful drugs and counseling without parental involvement for nebulous disorders or poorly applied and vague criteria for others. This objective appears to be a prominent reason why.

The Family Planning category contains several objectives that are responsible for the other major function of school-based and school-linked health clinics, that of reproductive health care:[2]

- ✂"Increase the proportion of pregnancies that are intended"
- ✂"Reduce pregnancies among adolescent females"
- ✂"Increase the proportion of adolescent females who have never engaged in sexual intercourse before age 15 years"
- ✂"Increase the proportion of adolescent females who have never engaged in sexual intercourse"
- ✂"Increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease"

Although most parents and physicians would agree with all of these goals or at least their intent, the philosophy and science behind some of them and how they are taught and implemented is fraught with controversy. For instance, to increase intended pregnancies or reduce adolescent pregnancies, do abortion referrals increase? That sexual abstinence before marriage and monogamy within marriage is the safest and most effective way to avoid pregnancy and sexually transmitted diseases is indisputable. However, this is not communicated effectively in school-based clinics or sex education classes. Abstinence is often given only lip service while condoms and other contraceptives are distributed or abortion referrals are made in these clinics without

parental knowledge or consent. Teens are often not informed about the failure rates of condoms and other barrier contraceptives to prevent HIV infection and their total lack of effectiveness against human papilloma virus (HPV) infection which causes cervical cancer and kills more young women per year than HIV/AIDS. There is much more to say about the reproductive health aspect of SBCs, but the profiling/mental health/data privacy/parental rights/health care reform aspects will be focused on today.

Finally, in the Educational and Community Based Programs category is the following objective: "Increase the proportion of middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health."[3] Among the many concerns and objections to comprehensive school health programs are three main ones. First, these programs take time from legitimate academic subjects when our public school students are struggling to stay competitive internationally. Secondly, much controversy exists about the philosophy behind how these subjects are taught, as alluded to above in the discussion on reproductive health. Finally, efforts to prevent these risk behaviors results in the ever greater collection of personal medical and family data on children and the profiling of children, frequently incorrectly, based on that data.

GOALS 2000

Goals 2000 is the other head of the two headed beast embodying health and education reform. The eight mandates described as goals in this legislation provide the content standards or philosophy for the performance standards embodied in School to Work, as well as for the other programs that implement these mandates.

Goal (mandate) number one states, "All children *will* start school ready to learn." This is a noble sounding goal, but it raises obvious questions like: How and at what point will a child be ready? Who determines that readiness? How soon and how much will a child be monitored to see if he is ready? What means will be used to make a child ready? What about the beliefs and desires of her family?

To answer some of the above questions, then Surgeon General Joycelyn Elders stated at a dinner on September 16, 1993 that part of fulfilling that goal (mandate) was to make sure that every child was a planned and wanted child so that it would be seen to that that child would start school ready to learn. To accomplish this, she spoke of the need for partnerships between government, schools, churches, homes, and community, as well as the need for SBCs, school/community services and the implantable contraceptive, Norplant.[4]

Goal (mandate) number eight states, "Every school *will* promote partnerships that will increase parental involvement and participation in promoting the social, emotional, and academic growth of children." This is another laudable goal, but it also raises questions such as: Who determines and by what standards adequate social, emotional, and academic growth ? What sort of parental involvement will the schools demand? Who has the primary responsibility for raising children, parents, as affirmed by the US Supreme Court in *Pierce vs. Society of Sisters*, or government

schools?

If the answers to the above questions are found in quotes from major stakeholders in the Goals 2000/School to Work system and from government documents, there is not much comfort for freedom loving Americans including parents who want to direct the upbringing of their own children free from government interference. Consider these examples:

- "...all persons, agencies, and institutions with whom 0-6 year old children interact *should be held responsible (*emphasis added*)* for enhancing their development, thus contributing to their preparedness for school. This requires collaboration with representatives from the health, medical, child care, and education communities." [5]

- Schools must be responsible for seeking the full involvement of parents as partners in the education of children...[and] for seeking parent involvement in all facets of development. *When parents cannot or will not become involved, schools must help the child overcome that difficulty* (emphasis added)." [6]

- "Schools in the new system must be responsible for ensuring collaboration with health and human services agencies to reduce barriers to student learning. Children of all ages must be physically, mentally, and emotionally healthy if they are to learn...Hunger, *stress (emphasis added)*, or illness will keep students from school success. *Schools must be responsible for eliminating those barriers to success* (emphasis added)."[7]

The first quote does not mention parents at all and if it did, would apparently hold them responsible for the upbringing of children according to government standards. The second one would have the school become the parents if not meeting the requirements of the schools. In the third quote, it is the schools, not parents that must break the barriers to learning, nebulous conditions like stress are included, and again one wonders who it is that will decide and by what standards if a child is mentally and emotionally healthy. The language in this third quote from a state business group is remarkably similar to the national goal (mandate) number eight.

Perhaps another way to induce parental involvement is the use of parent report cards, as is being done in Chicago, Illinois. These report cards evaluate parents on such items as whether the child has had breakfast or if he remembered his eyeglasses.[8] Apparently, the school board does not think that parents are solely responsible for the education of their children and that the parents should answer to the school instead of the other way around.

Still another way to achieve parental involvement is exemplified at the Leonardo da Vinci Magnet School (K-8) in Sacramento, California where parents sign contracts with the school. Each family is required to participate 40 hours per school year for one child. Activities receiving credit include baking, driving, baby-sitting children of families working at the school, and parent training. Activities *not* receiving credit include parent conferences and classroom observation. It is an odd paradox that those activities that would actually enhance a student's academic performance do not receive credit. In addition, the contract states, "All hours submitted are

subject to verification and discretionary approval by the parent coordinator." This "voluntary" participation must meet the school's standards.[9]

SCHOOL TO WORK

Shortly after Bill Clinton was elected president in 1992, Marc Tucker, president of the National Center for Education and the Economy (NCEE), wrote a letter to Mrs. Clinton in which he outlined his vision for the merging of education and labor in what would become Goals 2000 and STW. He says, "First, a vision of a kind of national – not federal – human resources development system the nation could have. This is interwoven with a new approach to governing that should inform that vision. What is essential is that we create a seamless web of opportunities to develop one's skills that literally extends from cradle to grave and is the same system for everyone - young and old, poor and rich, worker and full-time student."[10]

Here is one prominent place where our children are referred to as "human resources." It is also quite obvious that the "seamless web...that literally extends from cradle to grave" is prominent in America if one looks at the myriad connecting and overlapping programs of health, education and labor that have been put in place using the principles outlined in his letter and other writings. Marc Tucker joined with Hillary Clinton and Ira Magaziner to develop Goals 2000 and School to Work, starting when Bill Clinton was Governor of Arkansas.

It is interesting that the exact language from Marc Tucker's letter is in other federal programs and in states all across the country that supposedly have unique plans developed voluntarily on the state and local levels. For example, Secretaries Riley and Shalala say in their 1994 joint statement on School Health, "The benefits of integrated health and education services can be achieved by working together to create a seamless network of services, both through the school setting and through linkages with other community resources."[11] Similarly, Minnesota's STW contract with the federal government says "Minnesota's vision is to create a seamless system of education and workforce preparation for all learners tied to the needs of a competitive economic marketplace."[12]

What are some of the consequences of STW? Because other panelists have covered this much more in depth today, only this brief list will be offered:

- ✂It injects the federal government into the development of curriculum and standards to meet the needs of business.
- ✂STW forces students to choose career pathways by no later than the 10th grade and often by the 8th grade.
- ✂It does not educate beyond entry level.
- ✂It mandates the integration of workforce training and proper work attitudes into all curricula at all grade levels for all students.
- ✂ STW also mandates school based and work based learning for all students.
- ✂It awards skills certificates based on performance based assessments according to the Secretary's (of Labor) Commission on Achieving Necessary Skills (SCANS), which have little or nothing to do with core academics.
- ✂Finally, it establishes a new form of governance through appointed groups like governors' workforce development councils and local STW partnerships that

circumvent duly elected state legislatures and school boards.[13]

The work-based learning aspects raise safety, child labor and liability issues. A St. Cloud, Minnesota teen lost an arm while using dangerous machinery during a STW program. Young children who visit hospitals may be exposed to contaminated blood and body fluids. Much needs to be discussed in this area.

In order to track students into careers based on the needs of the local economy, the data collection aspects of STW must be substantial. The assessments involved are based on attitudes and beliefs as exemplified in Pennsylvania's Educational Quality Assessment (EQA), whose interpretive literature stated that it was trying to determine a student's "locus of control," whether he is "intrinsically or externally motivated," "amenable to change," "conforms to group goals," "willingly receives stimuli," or "will comply with authority figures."[14] Other assessments are related to individual performance tasks and packages that are part of the curriculum. Surveys on a variety of topics are also used liberally. Parents are given the possibility to opt their children out, but many never find out about them until after they are given.

Several Minnesota government documents link the state level Goals 2000 (called the Profile of Learning) and STW programs to each other and to their federal counterparts. One key component of both of these programs on the state level is the "lifework plan." It is defined this way in Minnesota's STW contract with the federal government: "Individualized Lifework Planning and Guidance - ALL Minnesota learners will develop a lifework plan which will be included as one component of the stated Profile of Learning....The lifework plan includes the following components:

Learners demonstrated mastery of academic and work skills (a portfolio of the learner's progress);

The following discussion of portfolios was obtained from the program of the 2000 Minnesota STW Conference: "Looking for a way to record student's career exploration activities starting with *kindergartners* (emphasis added)? Then this session is for you. We have developed an electronic career portfolio, career exploration and information center. A program that students (K-12), teachers and parents can use to explore and store student *personal information* (emphasis added), plus a link to vast information on the Web. The program can be personalized and adapted to meet your school needs. The Program can run on one machine, network or web based."

The Minnesota Goals 2000 Technology plan says: ""To receive a diploma a student must produce a record of work in a number of content standards. This record will show a student's achievement in relation to the high standards. (Profile of Learning)...The purpose of this record is to inform students, parents teachers and related services personnel about the progress of all students. In addition, *the record is intended to communicate student achievement to future employers.* (emphasis added)[15]"

Special accommodations and/or services a learner may require to successfully achieve educational and career goals;

A *cumulative history* (emphasis added) of the practical knowledge learners gain in relation to applied learning and work-based experiences....."

Another Minnesota Department of Children Families and Learning (DCFL, formerly Dept. of Education) document says the following about lifework planning:

> "A lifework plan is a personal information system. It is a personal plan for the future that takes account of work and other aspects of a person's life."
>
> "A lifework plan should: cover all areas of the learners life....take account of a behaviors and skills....reflect on the learner's dreams and ideals... include a record of the past as well as plans for both the short term and long term future."
>
> "Beginning at age 14, every student must have a written plan for transition that address long and short term goals and activities in five areas: employment, post-secondary education, home living, community participation and recreation - leisure."[16]

Since when did the government through the schools begin recording and monitoring dreams and plans for home life and leisure for future employment?

Besides these data collections on the local and state levels, Minnesota, California and two other states are part of a pilot project of the Department of Labor to develop a nationwide employment data system that is currently called Occupation Information Network (O*NET) This system contains a list of "model worker characteristics." Some of these characteristics are moral values, social orientation, and adaptability that are then going to be kept in a federal government database for use by potential employers.[17]

Several key points about data privacy and STW are obvious from reading the above quotes. First, data in this system follows the student from kindergarten. Actually, as will be described below, due to the early childhood programs, data is recorded from birth and includes medical data. Secondly, these academic, medical, and employment data are or will be merged and follow a child throughout his life on all levels of government, similar to the dossiers in the former Soviet Union and Communist China, literally from "cradle to grave." Finally, the government will be monitoring attitude, belief, and value data of individual citizens. How long will it be before there could be state controlled thought? Is this what we want in a constitutional republic?

MEDICAID/EARLY, PERIODIC, SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)/ELEMENTARY AND SECONDARY EDUCATION ACT (ESEA)/ INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

After the failure of the Clinton health care reform plan in 1993, documents were found in the National Archives from the Health Care Task Force revealing plans to implement universal health care through the schools via Medicaid. Public schools were called "a captive audience...for school-based clinic initiatives and ...into the broader system of health care."[18]

At a 1993 dinner speech, then Surgeon General, Dr. Joycelyn Elders, publicly nodded "yes" when hearing this statement from a floor microphone: "As I see it, the infrastructure is in place for Medicaid to become the universal health care coverage." [19]

During the health care debate, Ira Magaziner agreed with her, saying, "...the traditional health insurance industry will disappear...Medicaid would merge into the main health care system." Mr. Magaziner was involved not only in health care reform, but in education reform as well.

In 1994, Dr. Elders gave a speech on adolescent pregnancy and said, "In a part of the federal health care reform bill, there is a piece called the Youth Initiative, and there's money in there for comprehensive health education from K-12, and there's money in there for over 5,000 school-based clinics for schools that have a high percentage of high risk students in their schools."[20]

As mentioned, school-based clinics are the mechanism for the increased delivery of health and social services in the schools. While no one would disagree that they provide some valuable services, such as athletic physicals, their two main areas of function are fraught with controversy and hold the greatest dangers of loss of parental control in the health care of their children, data privacy concerns, and philosophical differences that can have life altering consequences for the student and the family. Those areas are mental and reproductive health care services.

Often students are referred for these services without parental knowledge or consent or after a blanket consent that is supposed to cover routine physical health care. If the parents do find out, they often cannot see the records due to legal constraints while their insurance is still billed for the services affecting the parents' coverage limits and the child's future employability and insurability.

Medicaid funds have been used for a myriad of purposes in schools, sometimes for purposes that have little to do with health care or academics. Consider the following two passages from a 1996 letter written by Medicaid consultant Jean Rowe chastising a school district in Illinois for not taking enough advantage of Medicaid funding:

> "Medicaid...has been expanded to cover not only therapies, but also social work and psychological services, nursing and audiological services, hearing/vision screening, and transportation."
>
> "Medicaid dollars have been used for...audiometers to mini-buses, from a closed captioned TV for a classroom, to an entire computer system, from contracting with substitutes to employment of new special education staff, from expanding existing social education programs to implementing totally new programs. *The potential for dollars is limitless.*" (emphasis added)

The list of diagnoses and situations covered by Medicaid/EPSDT is long, and as can be seen from the partial list below, some of these conditions like math or reading deficiencies caused by the breakup with one's boyfriend or girlfriend are far fetched at best. It must be remembered that the Diagnostic and Statistical Manual (DSM) of the American Psychological Association has no entry for normal:

- ✂Attention Deficit Disorder
- ✂Reading deficiencies
- ✂Math deficiencies
- ✂Breaking up with one's boyfriend or girlfriend causing reading or math deficiencies
- ✂Public awareness

- ✂Identification and referral
- ✂Initial health review and evaluation
- ✂Family notification
- ✂Health provider networking
- ✂Care planning and coordination
- ✂Immunization program management
- ✂Family planning referral
- ✂***At risk***

There is the diagnosis of attention deficit disorder, which is sadly becoming the most frequently diagnosed mental disorder of childhood. Again, one needs to ask serious questions about the validity of a diagnosis often made in 15 to 20 minutes in a harried pediatrician's office when there is federal funding at stake for the school and or the child's family. Even if there are true attention problems not attributable to classroom, home, nutritional or other problems, not a single study in 50 years of use and evaluation in the peer reviewed medical literature has found Ritalin to have long term academic or social benefits. The drug has serious side effects that need to be further evaluated, and there are no long term studies on the effects this drug has on the brains of growing children.

Identification and referral requires more gathering of data as well as the spending of taxpayer dollars to identify clients who will require the spending of more taxpayer dollars for things such as an aid to ride home with Johnny if he is stressed by the class bully.[21] The family planning referrals are fraught with medical and social controversy. If all else fails for the social planners in the schoolhouse, there is the category of "at risk." Any child who does not meet the behavioral and mental health goals of Goals 2000 or Healthy People 2000 is at risk of being at risk.

Some problems with Medicaid involvement in SBCs are listed below:

- ✂Medicaid Costs have skyrocketed
- ✂Back door implementation of failed national health care
- ✂Turns schools into Medicaid providers
- ✂Pushes nurse practitioners to prescribe medications
- ✂Data privacy concerns
- ✂Labels children for life
- ✂Parents not involved
- ✂Use of Medicaid dollars for other school projects and initiatives
- ✂Complex Medicaid coding
- ✂Little or no state legislative oversight

From the child's and family's perspectives, the biggest problems on this list are the lack of autonomy of the parents, the data privacy concerns, being tagged with a diagnosis that will follow the child forever affecting employability and insurability, and finally the risk of having physicians or nurses in SBCs prescribe medications without a full medical history. From the constitutional/taxpayer perspective, no legislative oversight and implementing unpopular programs surreptitiously are the gravest problems.

CARING COMMUNITIES

In 1993, the Departments of Education and Health and Human Services jointly published a document called *Together We Can: A Guide for Crafting a Profamily System of Education and Human Services.* This was one of the first government discussions of the merging of health care with education, just as Marc Tucker's letter was the first discussion of the merging of labor and education. The foreword states, "*Together We Can* is a practical guide that can assist local communities in the difficult process of creating a more responsive education and human service delivery system. The guidebook emphasizes the effective delivery of supports for families, a crucial step toward assuring the future success of America's children...It encourages a holistic approach in treating the problems of children and families; easy access to comprehensive services; early detection of problems and preventive health care services; and flexibility for education, health and human services."[22]

It appears, according to this, that there is a program for every problem and that families are just one of many partners in raising their children. This quote makes one think that families cannot do a single thing for themselves or their children without looking to the government. The "village" mentality is everywhere. This attitude is confirmed when one of the items on the checklist in the Appendix asks, "Has the collaborative conducted a comprehensive community assessment that...produced a profile of child and family well-being in the community?" Since when is it the government's job to do that?

There are plans, especially through private foundations to expand the medical and social services of school-based clinics to provide comprehensive school health as described above. Other names for this phenomenon are full service schools and community schools.

OTHER RESULTING AND RELATED PROGRAMS

A number of state and national programs have arisen out of efforts to comply with the goals (mandates) of Goals 2000, Healthy People 2000, and all of these other programs. Some were in operation before Goals 2000 and the other national programs became law and have expanded since then, while others have developed in conjunction with or because of them. Many of the programs were funded by large foundation grants either in the beginning to get them started or later to keep them going after they have been rejected by elected members of representative government. That is the case with health care reform which was kept going by the Kids First program for SBCs funded by the Robert Wood Johnson Foundation.

One example of these related programs is Parents as Teachers. This program began in Missouri in 1981 based on research by psychologist Dr. Burton White and his Harvard Preschool project. The program was based on his efforts to test his belief in the concept that "...public schools guide a child's learning from birth rather than from kindergarten."[23] This program is one of the first in the country to employ the concept of the home visitor/educator, and has now expanded into 40 states and 4 foreign countries. It involves certified parent educators who visit young parents either at home or at a school and offer advice on childrearing. Extensive data gathering occurs for the child and family that follows the child throughout life. Checklists have vague items such as: "Parent does not compress lips, grimace, or frown when making eye contact with the child."

In addition to the checklists, there are also twelve "at risk" designations that can be quite subjective and there is no category for normal. Two examples are:

- ✂Inability of the parent to relate or connect to the child
  - ❿ Does the parent usually ignore the child?
  - ❿ Does the parent fail to give the child affection or exhibit a caring attitude?
  - ❿ This also includes the parent who is not able to understand the baby's cues and/or have an effective parent-child relationship.

- ✂Other - This can include a wide variety of conditions that can potentially impact a child's development. Consider such things as:
  - ❿ Allergies
  - ❿ Heavy cigarette smoke in the home
  - ❿ Family history of hearing loss as indicated by the Semel questionnaire
  - ❿ Lack of stimulation or over-stimulation
  - ❿ Predominantly inappropriate or very few toys
  - ❿ Total lack of routine in the home
  - ❿ Include other individual concerns[24]

The parent educators are mandated child abuse reporters. Although intentions are wonderful and some of the things listed above are important to children's health and development, questions still need to be asked, such as: How much potential is there for a charge of child abuse and neglect due to philosophical or religious differences between the parent educator and the parents? How well can some of these very nebulous standards be assessed? Are parents aware of the autonomy and privacy that they may potentially lose when they sign up for this program? What is the quality and amount of training that the parent educators receive?

Dr. White resigned his position as head of Missouri's program because he felt there was not enough training for the educators and that there was not rigorous enough evaluation. The training was less, the pay lower and the turnover higher than in the original pilot project. There has been a study from Texas showing no gain for children in the program there due to what he says are these types of problems.[25]

Apparently he was not worried about parental rights abuses in his program or in his philosophy when he spoke about the related issue of licensing parents saying, "If it is indeed true that what parents do with their very young children has lasting, powerful effects, then it seems that licensing may not seem to be such a farfetched notion."[26]

Another is the Healthy Families America home visitation program developed by Prevent Child Abuse America (formerly the National Committee to Prevent Child Abuse). No study has found any statistically significant reduction in child abuse and neglect reports in families enrolled in the various forms of the program throughout the country, and some have had actual, though not statistically significant increases in these reports.[27] Substantial data gathering occurs in this program as well. This data collection concerned Congressman Henry Hyde, chairman of the House Judiciary Committee so much that in an October, 1998 letter to colleagues he called home visiting "cradle-to-grave tracking of newborns" and "big brother intervention as we have never

seen before."[28]

Other worrisome issues related to these programs include unconsented review of private medical records, whether consent is informed and voluntary for participation, that the home visitors are required to have only a minimum of 5 days of training, that they may be presenting information that is not scientifically supportable or violates the government's duty to maintain neutrality with respect to deeply held personal beliefs, that the investigative role of the home visitors is not made clear, and that participants are submitting to a search of their homes without informed consent violating their 4th Amendment rights.[29]

Before concluding with proposed solutions, two final examples of Minnesota state documents that exemplify the goals of Goals 2000 as well as the "village" mentality are provided. The first is the list of Early Childhood Outcomes and Indicators produced by the Minnesota Department of Children, Families, and Learning (DCFL). Area VII, Children Reach Their Individual Developmental Potential, is particularly illustrative and the outcomes are listed below:

- ✂Percentage of children showing individually developmentally appropriate progress in their social development
- ✂Percentage of children showing individually developmentally appropriate progress in their emotional development
- ✂Percentage of children showing individually developmentally appropriate progress related to their moral development
- ✂Percentage of children showing individual progress in their approaches to learning (i.e., curiosity, persistence, attentiveness, reflection, interpretation, imagination, and invention)

The same type of questions must be asked yet again. How does the state standardize individually developmentally appropriate outcome, and do we want the state doing that for very young children? This very same state bureaucracy publishes a brochure titled "Their Minds are in Our Hands." This brochure features on its cover a pair adult hands holding the head of an infant with that title and the DCFL logo in the corner. Although quite unintentionally, this arm of the state government has created a powerful and frightening image and it is appended to my testimony.

Finally, there is a document in the Minnesota School Health Guide (handbook for school nurses) called Guidelines for Early Identification of Mental Health Needs in Children and Youth. It contains criteria for identifying different mental health problems in children from newborn to adolescent. At the end of every section divided by age is the following statement: "From observation, is there anything unusual or disquieting that was observed in the interaction between the parent and the child that could reflect a lack of knowledge of appropriate parenting skills or a possibility of maltreatment? Record your observation and *consider this sufficient for a referral* (emphasis added)." The identical concerns continue to be raised by these documents. A referral to child protective services or for mental health services can stay with a child or family forever. Shouldn't these potentially life altering referrals be free from potential conflicts of interest related to ideology and federal funding?

SUMMARY AND PROPOSED SOLUTIONS

First, starve the beast of Medicaid funding through all of these various federal programs, such as

EPSDT, Goals 2000, IDEA, and ESEA. The pressure and conflict of interest for a school to 'bring home the bacon" would be eliminated as would this back door implementation of national health care that has failed miserably in other countries.

Secondly, increase Congressional and state legislative oversight of these programs. This will likely include decreasing foundation participation and partnerships, which too often prevents proper oversight.

Thirdly, there should be explicit opt-in procedures after informed consent for the gathering and dissemination of student and family data. There is a merging of academic, medical, and now employment through the schools that allows government far too complete a picture of every aspect of our children's lives. In the case of home visitation programs, vulnerable young families need to be properly appraised of the potential loss of autonomy and constitutional rights inherent in these programs.

Fourth, there also need to be explicit consent obtained for screening, testing, assessing, and referrals for physical and mental health treatment in the schools and an option for parents to review and object to any test, survey, screening, or curricular materials.

Finally, and most importantly, we need to remember the primary mission of our schools. It is to teach our children core academics of a liberal arts education that will allow them to become responsible citizens in our constitutional republic and give them the framework to pursue any career that our fast-growing, entrepreneurial economy needs at the time they are ready to pursue it. They do not need goals, attitudes, beliefs or job skills to be tracked into entry level jobs. We have the most freedom and the greatest economy of any country on the face of the earth. Let us not sacrifice our precious children and our freedom to ideas that have failed miserably everywhere they have been tried. Thank you.

[1]Healthy People 2000 and 2010: National Health Promotion and Disease Prevention Objectives, US Department of Health and Human Services, 1990 and 2000, http://www.health.gov/healthypeople/Document/tableofcontents.htm (Although the 2000 report is referenced here, the objectives are the same).

[2]ibid.

[3]ibid.

[4]As discussed in *Health and Education Reform: Freedom's Voluntary Demise?*, Smith, 1997, Life's Silver Linings, St. Louis, Missouri, p. 331

[5]*Roots and Wings* design team of the New American Schools Development Corporation (federally funded model for outcome based education) as quoted in *Brave New Schools*, Kjos, 1995, Harvest House Publishers, Eugene Oregon, p. 162

[6] Eight Principles that Must Guide the Transformation of Today's Iowa Schools into the World Class Schools of Tomorrow - Iowa Roundtable, as quoted in ibid., p. 163

[7]Eight Principles that Must Guide the Transformation of Today's Iowa Schools into the World Class Schools of Tomorrow - Iowa Roundtable, as quoted in ibid., p. 163-4

[8]http://www.cnn.com/2000/US/05/19/grading.parents.ap/index.html

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[10]— Marc Tucker, President, National Center On Education and the Economy, Letter to Hillary Clinton [following the 1992 election]

[11]"Joint Statement on School Health," April 7, 1994, Secretaries of Education, and Health and Human Services, Journal of School Health, Vol. 4, No. 64

[12]Minnesota School to Work Initiative, August 26, 1996, p. 1

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[14]As quoted in *The Cloning of the American Mind: Eradicating Morality Through Education*, 1998, Eakman, Huntington House, Lafayette, Louisiana, p. 13

[15]Minnesota Goals 2000 Technology Plan, p.4

[16]Quotes from "Lifework Planning," from the MN DCFL, pages B-3 through B-11.

[17]U.S. Department of Labor, Occupation Information Network, Content Model Worker Characteristics (http://dolea.gov.programs/onet/workchar.htm)

[18]Eakman, op. cit., p. 370

[19]Dinner speech at the invitation of the Missouri Public Health Association, U. S. Surgeon General Dr. Joycelyn Elders, September 16, 1993, Henry VIII Restaurant, St. Louis, Missouri, as quoted in Smith, op. cit. p. 112

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[28]Infant Home Visiting: Families Under Surveillance, Brase, Citizen's Council on Health Care Issue Brief, February 12, 1999

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